HCY SCREENINGS

Developmental/Mental Health Partial Screens are billable by a psychologist, LCSW or LPC with the new codes. These screening codes do not use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a 59 modifier and if the child is referred on for further care a UC modifier. The diagnosis code V202 is the only valid diagnosis code for a partial HCY screening.

99429 59	$15.00
99429 59 UC	$15.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

MODIFIERS

Effective for dates of service November 01, 2003 and after claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist
AJ – Licensed Clinical Social Worker
UD – Licensed Professional Counselor
U8 – in home (12) or private school (99)
(The U8 modifier is not appropriate when billing 90853 regardless of POS)

Effective for date of service August 21, 2005 and after, a new modifier has been added for use to track services provided to patients identified as catastrophe/disaster victims in any part of the country. This new modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

CR – Catastrophe/Disaster Related

FREQUENTLY USED PLACE OF SERVICE CODES (POS)

04 – Homeless Shelter	11 – office
12 – Home	14 – Group Home
21 – Inpatient Hospital	22 – Outpatient Hospital
33 – Custodial Care Facility	50 – FQHC
51 – Inpatient Psychiatric Facility	56 – Psychiatric Residential Treatment
61 – Comprehensive Inpatient Rehabilitation Facility	
72 – Rural Health Clinic	99 – Private School

Refer to the Special HIPAA bulletin dated September 30, 2003 or the CMS Web site for complete list of POS codes and additional description information.

TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service, which represents 20-30 minutes, must include at least 20 minutes **face-to-face** with the client. When less than 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 30-minute increments to bill Medicaid for one (1) half-hour session of service. Appointments scheduled less than 30 minutes are deemed to be less than 20 minutes face-to-face and are not covered.

A unit of service, which represents 45-50 minutes, must include at least 45 minutes **face-to-face** with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 50-minute increments to bill Medicaid for a 45-50 minute session of service. Appointments scheduled less than 50 minutes are deemed to be less than 45 minutes face-to-face and are not covered.

Currently, the CPT definition for Assessment, Family Therapy with or without the patient present, and Group Therapy is not time limited; and DMS defines a unit of service as a half hour. (These therapies must be provided in full 30-minute units.)

Testing and Crisis Intervention are defined in the CPT as hour services and a full 60 minutes of services must be provided.

Travel time is not reimbursable and must not be included as part of the scheduled appointment time.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a psychologist, LCSW, or LPC. These codes are 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, *and 90870*.

Certain services are not covered when provided by an LCSW or LPC and may not be billed for an adult or child in any setting. These codes are 96101, 96103, 96105, 96111, and 96116.

Psychology/counseling services are not billable by a psychiatrist, PCNS, psychologist, LCSW or LPC in a nursing home setting. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862 in the nursing home setting.**

FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When Family Therapy without the patient present (90846) or Family Therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill for Family Therapy for each family member. This will be monitored by the Program Integrity Unit. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family Therapy furnished by an LCSW or LPC must be directed exclusively to the treatment of the child. **Parental issues may not be billed and Family Therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.**

A psychiatrist, PCNS, and psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

Only one (1) Prior Authorization will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's DCN must be used for Prior Authorization and billing purposes. When a specific child is identified as the primary recipient of treatment, that child's DCN must be used for Prior Authorization and billing purposes. Providers should not request more than one (1) Family Therapy Prior Authorization per family.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.**

GROUP THERAPY

Group Therapy must consist of 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient Group Therapy sessions also.

Group Therapy may not be billed on the same date of service as Family Therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. *Services must be provided at the facility location.* Group Therapy in a group home is billed with POS 14. Group Therapy in a residential/custodial facility is billed with POS 33. Group Therapy in a shelter type setting is billed with POS 04.

PLACE OF SERVICE CODE

Effective for dates of service July 01, 2005 and after, the only valid setting for using place of service code 99 is a private school. (Head Start is not considered a private school.)

Place of service 99 cannot be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers must use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may not be billed to Medicaid. Although there is a place of service 15 for mobile unit, Medicaid does not cover services provided in this setting.

Place of service 11 (office) is to be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) has defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

SCHOOL BASED SERVICES

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located. A Missouri Medicaid provider number is required for each school district where services are being provided. The only appropriate place of service for a public school setting is 03 and must be used.

DIAGNOSIS CODES

The diagnosis code must be a valid ICD-9 diagnosis code and must be mental health related. This does not include mental retardation. The only valid code ranges for the psychology/counseling program are *295*-316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. An appropriate 4th or 5th digit may be required for the diagnosis code to be valid.

DOCUMENTATION REQUIREMENTS

DIAGNOSTIC ASSESSMENT

A current Diagnostic Assessment a defined in CSR 70-98.015 from a Medicaid enrolled provider must be documented in the client's medical record. This assessment will assist in ensuring an appropriate level of care, identifying necessary services, developing a treatment plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services; the family's perceptions when appropriate and available
- Presenting problem and referral source
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions
- Current medications; medication allergies/adverse reactions
- Recent alcohol/drug use for at least the past 30 days; a substance abuse history including duration, patterns, and consequence of use
- Current psychiatric symptoms
- Family, social, legal, and vocational/educational status and functioning. Historical data is also required unless short-term crisis intervention or detoxification are the only services being provided
- Current use of resources and services from other agencies
- Personal and social resources and strengths, including availability of family, peer, and other natural supports
- Multi-axis diagnosis or diagnostic impression according to the current edition of the DSM or International Classification of Diseases, Ninth Revision (ICD-9). The ICD-9 code is required on the treatment plan for billing purposes.

PLAN OF TREATMENT

A current Plan of Treatment as defined in CSR 70-98.015 is required documentation as part of the client's medical record. A treatment plan must be developed based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and reflects the need for psychology/counseling services. The Treatment Plan must be individualized to reflect the unique needs and goals of the client. The Treatment Plan must include but is not limited to the following:

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
  - Services, supports, staff member responsible,
  - Actions required of the recipient, family, peers, etc.
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

TREATMENT UPDATE:

The Treatment Plan must be reviewed on a periodic basis to evaluate progress towards goals/outcomes and to update the plan. Each client will participate in the review of his/her treatment plan. The frequency of plan reviews is based on the level of care or other program rules. A crisis or significant event may require additional review and the treatment plan must be updated and changed as indicated. Each update must include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress towards goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications. Plans for continuing treatment and/or termination from therapy and aftercare must be expressed in each Treatment Plan update.

PROGRESS NOTES

Progress Notes as defined in CSR 70-98.015 must be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed. A check-off list or pre-established form is not acceptable as sole documentation. Progress notes for Psychology/Counseling services must specify:

- First and last name of client
- Specific service rendered
- Date (month/day/year)
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and recipient's response
- Patient's progress towards goals in treatment plan
- FamilyTherapy - must identify each member of the family, first and last name, included in the session and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient response, and progress toward specific goal
- Group Therapy - must identify the number of group members present and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient's response, and progress towards goals

(FYI – These are generalized points of CSR 70-98.015. Providers should refer to this rule for a complete description of the documentation requirements.

Note: If **Individual Interactive Therapy** is provided, the documentation must include the need for this service and the type of equipment, devices, or other mechanism of equipment used. (This is specifically required per CSR 70-98.015).

If the service is for a child in the legal custody of the Children's Division (CD), a copy of the Treatment Plan must be provided to the CD.

These documentation requirements do not replace or negate documentation/reports required by CD for individuals in their care and custody. Providers are expected to comply with policies and procedures established by CD.

AFTERCARE PLAN

When care is completed, the aftercare plan must include, but is not limited to, the following:

- Dates (care) begin and end
- Frequency and duration of visits
- Target symptoms/behaviors addressed
- Interventions
- Progress achieved towards goals
- Final diagnosis
- Final recommendations including further services, providers, and activities to promote further recovery

For all medically necessary covered services, the stipulated documentation is an essential and integral part of the service. No service will be considered performed if documentation requirements are not met, and no reimbursement will be made.

Only the enrolled Missouri Medicaid provider can provide psychology/counseling services and be reimbursed. Missouri Medicaid does not cover services provided by someone other than the enrolled provider.

Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

Medicaid providers must retain for six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to Medicaid and must furnish or make records available for inspection or audit by the Department of Social Services or its representative upon request.

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW or LPC. The appropriate AJ or UD must be used for all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$24.00	6	Assessment
90801	U8	$29.00	6	Assessment-home/private school (PS)
90802		$24.00	2	Assessment-interactive (intac)
90802	U8	$29.00	2	Assessment-interactive-home/PS
90804		$24.00	1	Individual 20-30 mins
90804	U8	$29.00	1	Individual 20-30 mins- home/PS
90806		$48.00	1	Individual 45-50 mins
90806	U8	$58.00	1	Individual 45-50 mins- home/PS
90810		$24.00	1	Intac Indiv 20-30 mins
90810	U8	$29.00	1	Intac Indiv 20-30 mins- home/PS
90812		$48.00	1	Intac Indiv 45-50 mins
90812	U8	$58.00	1	Intac Indiv 45-50 mins-home/PS
90816		$24.00	1	Indiv hosp 20-30 mins
90818		$48.00	1	Indiv hosp 45-50 mins
90823		$24.00	1	Intac Indiv Hosp 20-30 mins
90826		$48.00	1	Intac Indiv Hosp 45-50 mins
90846		$24.00	2	Family w/o Patient
90846	U8	$29.00	2	Family w/o Patient-home/PS
90847		$24.00	2	Family w/ Patient
90847	U8	$29.00	2	Family w/ Patient-home/PS
90853		$10.00	3	Group Therapy
S9484		$48.00	6	Crisis Intervention, hour
S9484	U8	$53.00	6	Crisis Intervention, hour-home/PS

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a Psychologist. The AH modifier must be used on all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$30.00	6	Assessment
90801	U8	$35.00	6	Assessment-home/private school PS
90802		$30.00	2	Assessment-interactive (intac)
90802	U8	$35.00	2	Assessment-interactive-home/PS
90804		$30.00	1	Individual 20-30 mins
90804	U8	$35.00	1	Individual 20-30 mins- home/PS
90806		$60.00	1	Individual 45-50 mins
90806	U8	$70.00	1	Individual 45-50 mins- home/PS
90810		$30.00	1	Intac Indiv 20-30 mins
90810	U8	$35.00	1	Intac Indiv 20-30 mins- home/PS
90812		$60.00	1	Intac Indiv 45-50 mins
90812	U8	$70.00	1	Intac Indiv 45-50 mins-home/PS
90816		$30.00	1	Indiv hosp 20-30 mins
90818		$60.00	1	Indiv hosp 45-50 mins
90823		$30.00	1	Intac Indiv Hosp 20-30 mins
90826		$60.00	1	Intac Indiv Hosp 45-50 mins
90846		$30.00	2	Family w/o Patient
90846	U8	$35.00	2	Family w/o Patient-home/PS
90847		$30.00	2	Family w/ Patient
90847	U8	$35.00	2	Family w/ Patient-home/PS
90853		$12.50	3	Group Therapy
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psych eval of records
96101		$60.00	4	Testing – admin by psychologist
96101	U8	$60.00	4	Testing – psychologist - home/PS
96103		$20.00	4	Testing – admin by computer
96103	U8	$20.00	4	Testing – admin by comp – home/PS
96105		$35.00	1	Assess of aphasia
96111		$35.00	1	Developmental testing, extended
96116		$35.00	1	Neurobehavior status exam
S9484		$60.00	6	Crisis Intervention, hour
S9484	U8	$65.00	6	Crisis Intervention, hour- home/PS

PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC, AND RHC

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90801		$30.00	6	Psy dx interview
90801	U8	$35.00	6	Psy dx interview, home/private school PS
90802		$30.00	2	Intac psy dx interview
90802	U8	$35.00	2	Intac psy dx interview, home/PS
90804		$30.00	1	Psy tx, office, 20-30 min
90804	U8	$35.00	1	Psy tx, 20-30 min, home/PS
90805		$35.00	1	Psy tx, off, 20-30 min w/e&m
90805	U8	$40.00	1	Psy tx, 20-30 min w/e&m, home/PS
90806		$60.00	1	Psy tx, off, 45-50 min
90806	U8	$70.00	1	Psy tx, 45-50 min, home/PS
90807		$65.00	1	Psy tx, off, 45-50 min w/e&m
90807	U8	$75.00	1	Psy tx, 45-50 min w/e&m home/PS
90810		$30.00	1	Intac psy tx, off, 20-30 min
90810	U8	$35.00	1	Intac psy tx, 20-30 min, home/PS
90811		$35.00	1	Intac psy tx, 20-30 w/e&m
90811	U8	$40.00	1	Intac psy tx, 20-30, w/e&m, home/PS
90812		$60.00	1	Intac psy tx, off, 45-50 min
90812	U8	$70.00	1	Intac psy tx, 45-50 min home/PS
90813		$65.00	1	Intac psy tx, 45-50 min w/e&m
90813	U8	$75.00	1	Intac psy tx, 45-50 min w/e&m, home/PS
90816		$30.00	1	Psy tx, hosp, 20-30 min
90817		$35.00	1	Psy tx, hosp, 20-30 min w/e&m
90818		$60.00	1	Psy tx, hosp, 45-50 min
90819		$65.00	1	Psy tx, hosp, 45-50 min w/e&m
90823		$30.00	1	Intac psy tx, hosp, 20-30 min
90824		$35.00	1	Intac psy tx, hosp 20-30 w/e&m
90826		$60.00	1	Intac psy tx, hosp, 45-50 min
90827		$65.00	1	Intac psy tx, hosp, 45-50 w/e&m
90846		$30.00	2	Family psy tx w/o patient
90846	U8	$35.00	2	Family psy tx w/o patient, home/PS
90847		$30.00	2	Family psy tx w/patient
90847	U8	$35.00	2	Family psy tx w/patient, home/PS
90853		$12.50	3	Group psychotherapy
90862		$12.50	1	Medication management
90865		$25.00	1	Narcosynthesis
90870		$30.00	1	Electroconvulsive therapy

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psy evaluation of records
96101		$60.00	4	Testing – admin by physician
96101	U8	$60.00	4	Testing – admin by phys – home/PS
96103		$20.00	4	Testing – admin by computer
96103	U8	$20.00	4	Testing – admin by computer – home/PS
96105		$35.00	1	Assessment of aphasia
96111		$35.00	1	Developmental test, extend
96116		$35.00	1	Neurobehavior status exam
S9484		$60.00	6	Crisis intervention, per hour
S9484	U8	$65.00	6	Crisis intervention, per hour home/PS

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home) or 99 (private school – PS) as indicated.

Procedure Codes

Effective for dates of service January 01, 2006 and after, procedure codes 90871, 96100, and 96115 are no longer valid codes for billing. These codes are valid for services provided December 31, 2005 and before.

Effective for dates of service January 01, 2006 and after, providers must use the new, appropriate procedure code when billing for testing, 96101 or 96103.

Psychological Testing may NOT be performed by an LCSW or LPC.

Psychological Testing administered by a technician (96102) is NOT a covered service.

Neuropsychological Testing (96118, 96119, and 96120) are NOT covered services.